

Home Care Standards Present Unique Medical And Legal Challenge

by Larry Shinnick

It was nearly 25 years ago that the American Medical Association (AMA) finally decided that jet travel was medically safe. I mention this curious fact only to underscore the amazing pace at which the process of technological innovation challenges the advancement of human health care. Nearly 15 years ago, severe birth defects such as when the baby's stomach organs are outside the body, had a 85% mortality rate. Today that rate is down to 5%. Ten years ago, spina bifida had a mortality rate of 90% — today the survival rate is 90%.

People with complex and multiple handicaps have the right to the best quality of life possible. This can be achieved only by providing them with medical, physical, social and psychological care sufficient to help them realize their maximum potential for health, education and self-fulfillment. To realize these goals, economic barriers to health care are being removed by the federal government. As an example, the 1976 Social Security Amendment provides social security insurance for disabled children. Many of these programs identify and provide services to crippled children because their health care costs are truly catastrophic.

Since modern medical technology has increased the survival rate of individuals with multiple and complex health care needs, the 1980s bring a real need to develop alternate methods of providing this health care. Institutional intensive care units, where the bulk of

these patients now receive their care, have provided an extremely high level of care, but have also been found to have two major drawbacks.

First, for optimum growth and development, the individual needs to be in the loving environment of his home as a member of the family. Secondly, institutional care is an expensive method of health care. It has been shown recently that the same services can be provided in the home with approximately a 60% reduction in costs.

As we all know, federal DRG (Diagnosis Related Group) regulations recently became effective Oct. 1, 1983. DRGs restrict the limits of reimbursement a hospital is entitled to receive for the care and services rendered to Medicare eligible patients. It has been predicted strongly and repeatedly that the number of and sophistication of services rendered in the home environment will be dramatically increased as a direct result of DRGs and by the passage of Medicaid waivers for certain services.

It seems clear that these two items are indicative of an increased awareness that high-tech services can be efficiently and safely rendered in the home environment. It is reasonable to predict that there will ultimately be a greater emphasis by both state and federal governments as well as other reimbursement mechanisms to encourage such services in the home. Thus, home care professionals will have to become cognizant of and willing to assume any and all increased and transferred liability

risk associated with the rendition of services in the home.

Until recently, ventilator-dependent children and adults have been cared for on an in-patient, in-hospital basis. Now sufficient technology exists to permit a significant number of ventilator patients to be cared for in their own home. By analogy then, it's possible to examine the various types of risks which health care personnel face in a hospital setting, and forecast the types of risks the home health care personnel should be willing and able to accept in the home care setting. It's long been established that physicians, nurses and other allied health care personnel must adhere to certain standards of care or be held accountable if the patient suffers injury or harm as a direct result of the providers falling below that standard of care. Generally speaking, that standard is known as that of a reasonable man — a standard by which a person is judged in accordance with what a reasonable person with similar training would have done under the same circumstances. By such a standard, the nurse, medical technician, or physician can be evaluated in his or her community by the standards that exist in that community. But this standard falls short of providing specific answers because it must, by its nature, be applied on a case-by-case basis.

Establishing standards for the home care of ventilator-dependent patients presents a unique medical and legal challenge. Consequently, home health care professionals should possess the requisite train-

ing and education enabling them to properly deal specifically in the home environment. Monitoring, supervision, provision of medication, observation and notation of important warning signs, patient charting, patient assistance, and timely summoning of physician assistance are all responsibilities that are present in the home setting. In theory, the duties and responsibilities of treating ventilator-dependent patients in the home would be extremely similar to treating ventilator-dependent patients in a hospital setting. The legal liabilities associated therewith would also be quite similar.

There are legal precedents that would adequately demonstrate that physicians and nurses and technicians have been successfully sued for violating applicable standards of care. By way of illustration only, health care professionals have been found liable recently in the following situations:

1. Failure of physical therapist to follow and adhere to the physician's order.
2. Negligent administration of an enema and of failure to report timely to the attending physician.
3. Mislabeling, mishandling of a blood sample by a nurse.
4. Improper injection of medication by a nurse.
5. Insufficient number of nurses assisting a patient in walking to a restroom.

These examples are drawn from the hospital environment but can be reasonably expected to occur in the patient's home. A more recent case occurred in Hawaii where a hospital was found to be negligent in failing to properly monitor a child's post-operative tonsillectomy. Specifically, it was found that the delay in discovering the child's respiratory and cardiac arrest was the result of failure to

monitor on a "minute-by-minute basis." One can readily see from this example the clear analogy to the degree of care observation in monitoring that would likely accompany ventilator-dependent cases in the home care setting.

I do not believe that home care is unnecessarily risky or dangerous. Home health care providers are well-advised, not only to consider, but also to evaluate and prepare for the potential liabilities that precedent has shown to exist.

While providing a safer and more comfortable environment for the patient, there are many things that home health care providers may do to substantially minimize malpractice risks discussed earlier. Among these are the following:

- Careful screening of potential employee credentials.
- Increased emphasis on continuing education.
- Keeping abreast of state-of-the-art technology.

Malpractice cases are definitely moving in the direction of requiring physicians and nurses and other health care personnel to remain current with the latest developments in medical technology. A central focus of such cases is prompt, complete and accurate patient charting, and adequate nurse supervision.

An important factor which will undoubtedly have legal ramifications, although the cases are not yet present in the books, is an acknowledgment by home care professionals that the atmosphere of caring for ventilator-dependent persons in their own home may vary substantially from the traditional in-hospital setting. Patients, their families, and their relatives may be more lenient about adhering to physician and nurse orders in the home. Once a health protocol has been established, it will be absolutely critical for home care

providers to assure strict compliance in spite of the attitude of the parents and families.

Another important factor in providing care for the ventilator-dependent persons in the home is the social and psychological advantages. As a parent myself, I can readily envision that a child receiving health care in the home would enjoy a better outlook on life. This certainly tends to offset the incremental increased risk of health care delivery outside the institutional setting.

It's my belief that recent developments in medical technology permit health care personnel to take advantage of the psycho-social value associated with caring for a patient in the home setting. Economic incentives intended to foster home care are now in place with the advent of Medicaid waivers and prospective reimbursement plans. Legal liabilities and malpractice concerns are ever present, and present reasonable questions which must be addressed openly. The study and analysis of liabilities that have arisen in the hospital setting, can be used to forecast home care legal risks. Such analysis permits the conclusion that recent advancements in medical and communication technology, taken together with continuing education, substantially reduce the legal risks associated with home care. Physicians and nurses and other health care professionals are quite correct that the benefits of the home care setting far outweigh the incremental risk of legal liability. The conscientious home care provider will be setting new standards for reasonable care in the community. These standards do not exist at the present time, but there is no reason to fear their development. There is no substitute for adequate training and for ongoing education. ●